

**State of California - Division of Workers' Compensation
Request for Authorization for Medical Treatment (DWC Form RFA)**

Must be accompanied by a medical report substantiating the requested treatment: the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021), a Treating Physician's Progress Report (DWC Form PR-2), or a narrative report.

All items marked with an asterisk (*) are mandatory fields and must be completed.

☐ Check box if the patient faces an imminent and serious threat to his or her health.

Patient Information

*Patient Name:
*Date of Birth:
*Date of Injury:
*Employer:
Claim Number:

Claims Administrator Information

*Claims Administrator:
Adjustor Name (if known):
*Address:
*City, State, Zip:
*Telephone Number:
Fax Number:

Physician Information

*Physician Name:
Practice Name:
*Address:
*City, State, Zip Code:
*Telephone Number:
Fax Number:
Physician Specialty:
Physician State License Number:
*National Provider ID Number:

***Requested Treatment: (See Instructions for guidance; attach additional pages if more space is required.)**

Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. **Only a single treatment request can be made on this form.** Use additional pages or attached additional evidence if needed.

*Date of Request

*Physician Signature

Claim Administrator Response Approving Treatment:

You may use this form for approving a treatment request. A request for additional information, or a decision to modify, delay, or deny a request for authorization cannot be made using this form. Please review all timeframes and requirements set forth in California Labor Code section 4610 and California Code of Regulations, title 8, section 9792.9.

A decision on the requested medical treatment must be made within five (5) working days from receipt of a complete and supported request for authorization, or 14 calendar days with a timely request for information necessary to render a decision. For an expedited request, one made in a case of imminent or serious health threat, the maximum is 72 hours. Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information.

Date of Approval

Date request for authorization received

Date of response to request

Approval tracking number (Optional)

Claims Administrator/Authorized Agent Signature

Adjuster/Authorized Agent Name (print)

Instructions for the Request for Authorization for Medical Treatment (DWC Form RFA)

Warning: Private healthcare information is contained in the Request for Authorization for Medical Treatment, DWC Form RFA. The form can only go to other treating providers and to the claims administrator.

Overview: The Request for Authorization for Medical Treatment (DWC Form RFA) is required to initiate the utilization review process required by Labor Code section 4610 and California Code of Regulations, title 8, section 9792.9. This form must be submitted by a physician and accompanied by a medical report substantiating the requested treatment: the Doctor's First Report of Occupational Injury (Form DLSR 5021), a Treating Physician's Progress Report (DWC Form PR-2), or an equivalent narrative report.

To minimize the amount of information repeated onto the request form by the physician, it is best to state the treatment request, other details of the treatment (e.g. frequency and duration), and the reason (a diagnosis or a clinical problem or concern). **Only a single treatment request can be made on this form.** Multiple requests involving different types of treatments must be divided and made on separate, individual forms. The benefit of single treatment requests is that each item can be approved separately; if any one item is delayed, modified, or denied, the other items can still be approved and faxed back separately.

Note: Items marked with an asterisk (*) on the DWC Form RFA are mandatory fields and must be completed. Failure to complete these items may result in the form being returned by the claims administrator. Unless accepted by the claims administrator, the receipt of an incomplete form will not initiate the response timeframes of 8 C.C.R. § 9792.9.

Expedited Review Checkbox: The first checkbox indicates whether review should be expedited based on an imminent and serious threat to the patient's health.

Routing Information: The DWC Form RFA can either be mailed or faxed to the claims administrator. The requesting physician must complete: (1) the patient's name, date of birth, date of injury, and employer; (2) the claims administrator's name, address, and telephone number and (3) the physician's name, address, telephone number, and National Provider ID number.

Instructions: The DWC Form RFA must contain all the information needed to substantiate the request for authorization. This may include, but not be limited, to the following:

- List the primary diagnosis, the requested treatment, and, if applicable, the frequency, duration, quantity, facility, etc. Reference to specific guidelines used to support treatment should also be included.
- CPT codes are helpful when known, but are optional. CPT codes are required for surgery.
- For surgery requests, attach or include relevant surgery orders, or pre- and post-operative orders (if known).
- If request is to continue a treatment plan or therapy, please attach documentation for functional improvement, if applicable, and state the number of additional necessary visits.
- For requested medical treatment that is: (a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at 8 C.C.R. § 9792.20, et seq.; or (b) for a condition or injury not addressed by the MTUS, include, or provide a detailed citation to, the scientifically based evidence published in a peer-reviewed, nationally recognized journal that recommends the specific requested medical treatment or diagnostic services:

Physician Signature: Signature/Date line is located under the requested treatment box.

Claims Administrator Response: Upon receipt of the DWC Form RFA, a claims administrator must log each request pursuant to 8 C.C.R. § 9792.11(j)(1) and respond within the timeframes set forth in Labor Code section 4610 and 8 C.C.R. § 9792.9. **Immediately return an incomplete form to the requesting physician.** To communicate its approval on requested treatment, the claims administrator may complete the lower portion of the DWC Form RFA and fax it back to the requesting physician. (Use of the DWC Form RFA for approval is optional; a claims administrator may utilize other means of written notification.) A copy of any retrospective approval must be sent to the individual who received the treatment and, if applicable, to their attorney/designee. **Claims administrators should review and familiarize themselves with the timeframes set forth in Labor Code section 4610 and section 9792.9.**